

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <u>Lida REBECCA AMOSS</u>			2a. DATE OF DEATH Month <u>MAY</u> Day <u>24</u> Year <u>1968</u>			2b. HOUR <u>12:10 AM</u>	
3. SEX <u>Female</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH <u>01-28-82</u>		6. AGE (In years lost birthday) <u>86</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>HARFORD</u> Md.	
10. CITY OR TOWN OF DEATH <u>HAVRE DE GRACE</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>CITIZENS NURSING HOME</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>HOMEMAKER</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MARYLAND</u>		13b. COUNTY <u>HARFORD</u>		13c. CITY OR TOWN <u>FALLSTON</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER		14. FATHER'S NAME First Middle Last <u>WILLIAM A DIVERS</u>		15. MOTHER'S MAIDEN NAME First Middle Last <u>MARY MARTHA SCARFF</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>218-54-3305</u>		17. INFORMANT <u>MRS ELIZ. HISER</u>		Address <u>P.O. Box 125 BEL AIR, Md 21014</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>486X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PNEUMONITIS AND ARTERIO SCLEROTIC</u> DUE TO, OR AS A CONSEQUENCE OF <u>CARDIO VASCULAR DISEASE</u> (c) <u>SENILITY</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 HOURS</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>492X</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY</u> , 19 <u>54</u> , to <u>MAY 28</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>MAY 24</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Philip W. Heuman M.D.</u> DEGREE ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/>				22c. DATE SIGNED <u>May 24, 1968</u>			
22d. PHYSICIAN'S NAME (Type) <u>PHILIP W. HEUMAN M.D.</u>				22e. ADDRESS <u>307 HICKORY AVE., BEL AIR, Md 21014</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>May 26 - 68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fallston Methodist</u>		23d. LOCATION (City or Town) (County) (State) <u>Fallston Harford Md</u>	
24. FUNERAL DIRECTOR <u>ARCHER FUNERAL HOME BENSON</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 28 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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VR A15 (4)
30M REV. 1-7-68

07078				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07084						
1. DECEASED-NAME (Type or print)				First		Middle		Last		2a. DATE OF DEATH Month Day Year			2b. HOUR A.M. P.M.	
Elizabeth S. Anderson				Elizabeth		S.		Anderson		5/16/68			11:30 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
Female		white		5/23/83				84 YRS.						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						Md.		
Md.		U.S.A.				Harford								
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY		
Havre de Grace				Citizens Nursing Home				Housewife				Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
Md.				Harford		White Hall				R.D. #1 Box 215				
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last										
Christopher Columbus Slade				Annie Hunter										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address								
No				213-42-3340 21342-3380		Garnet L. Anderson White Hall, Md. RD #1 Box 215								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4/29 Chronic Cardiac Decompensation 4-5 months DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D. ? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4221 DUE TO, OR AS A CONSEQUENCE OF (c) - PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Passive Congestion of Liver												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from Jan 1968, to 5/16, 1968, that (I) (we) lost saw the deceased alive on 5/16/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE				22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
Edward C. Loo, M.D.				5/16/68		Harford		Havre de Grace, Ind						
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)						
Burial				5/18/1968		Bethel		Madonna, Harford, Md.						
24a. FUNERAL DIRECTOR				24b. ADDRESS		24c. REC'D BY REGISTRAR		24d. DATE		24e. REGISTRAR'S SIGNATURE				
Charles E. Kurtz				Parrettsville		MAY 20 1968				Charles Judge				

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VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Bessie			M. Baity			Month Day Year 5 26 68			4:30 ^a
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR
Female		White		April 10, 1887			81 YRS.		MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Rocks, Md.		U.S.A.					Harford Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Havre de Grace, Md.			Citizens Nursing Home			School Teacher			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Harford		Jarrettsville				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Benjamin L. Mason			Annie E. Devoe						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			213-50-1940		Warren Baity, Darlington, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4221</u> (b) <u>A.S. C.V.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>> 5 years</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus, Chronic Cholecystitis * Terminal pneumonia</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from April 15, 1968, to 5/26, 1968, that (I) (we) last saw the deceased alive on 5/26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			22c. DATE SIGNED						
<u>Edward C. Loo, M.D.</u>			5/26/68						
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
Edward C. Loo, M.D.			Havre de Grace, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			May 28, 1968		Highland		Street, Harford, Md.		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
John H. Harkins			Delta, Penna.			DATE MAY 31 1968 <u>Charles Judge</u>			

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Johnston School

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) WILLIAM		First		Middle		Last		2a. DATE OF DEATH Month MAY Day 20 Year 1968			2b. HOUR 11:45 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH August 3, 1929.				6. AGE (In years last birthday) 38 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD Md.						
10. CITY OR TOWN OF DEATH HAURED GRACE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD MEMORIAL Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Civil Engineer			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 8608 Drumwood Rd. 21204				
14. FATHER'S NAME First Lionel Middle L. Last Bass				15. MOTHER'S MAIDEN NAME First Grebner Middle Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service) WW 2		16b. SOCIAL SECURITY NO. 214-24-1299		17. INFORMANT Mrs. Doris A. Bass				Address (Same)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4109 IMMEDIATE CAUSE (a) Acute Post. Myocardial Infarct DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 5/20 , 19 68 , to 5/20 , 19 68 , that (I) (we) last saw the deceased alive on 5/20 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE [Signature]				DEGREE Phys.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/20/68				
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS Harford Memorial Hospital								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/23/68.		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.						
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 21 1968		25b. REGISTRAR'S SIGNATURE [Signature]				

MEDICAL CERTIFICATION

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MAIL ROOM

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
JOSEPH			NORMAN			BOISSONNEAULT			Month Day Year May 30 68
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
Male		Cau		22 Apr 1918			50 YRS.		1530 M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
New Hampshire		USA					Harford Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Aberdeen Pr. Gd.			Kirk Army Hospital			SOLDIER			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Maryland			Harford		Aberdeen	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3 Defense Dr.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Louis			Boissonneault			Marie Ange Leur			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT				
Yes			001-14-1925		Helene Boissonneault, 3 Defense Dr. Aberdeen				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>									1-4 Hrs
4109 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (did not) attended the deceased from 30 May 1968, to 30 May 1968, that (I) (we) last saw the deceased alive on 30 May 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE								22c. DATE SIGNED	
[Signature]								30 May 68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
MARK J EPSTEIN CPT MC				US KIRK ARMY HOSPITAL, APG, MD 21005					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		4 June 68		Post Cemetery		Aberdeen Proving Ground, Md.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Tarring Funeral Home Aberdeen, Md. 21001					DATE JUN 3 1968		[Signature]		

07082

FOR: [illegible]

DATE: [illegible]

TIME: [illegible]

BY: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>George Herbert Bond</i>			2a. DATE OF DEATH Month <i>MAY</i> Day <i>20</i> Year <i>1968</i>			2b. HOUR <i>9:45 A M</i>					
3. SEX <i>MALE</i>		4. RACE <i>Colored</i>		5. DATE OF BIRTH <i>JAN 20. 18. 89</i>		6. AGE (In years last birthday) <i>79</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i>	
7a. BIRTHPLACE (State or foreign country) <i>md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>US</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>HARFORD</i> Md.					
10. CITY OR TOWN OF DEATH <i>HAUREDE GRACE</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>HARFORD MEMORIAL</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i></i>			12b. KIND OF BUSINESS OR INDUSTRY <i></i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>md.</i>			13b. COUNTY <i>HARFORD</i>		13c. CITY OR TOWN <i>BELAIR</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>RFD 1 Box 370 A</i>		
14. FATHER'S NAME First Middle Last <i>William Bond</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i></i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i></i>			17. INFORMANT Address <i></i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>441.1</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Artery Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis of C. & A. Arteries</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>36 hrs</i> <i>3 min</i> <i>8 yrs</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>451X Pulmonary</i>											
19a. DATE OF OPERATION <i></i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i></i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i></i>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i></i>						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i></i>			21f. LOCATION Street or R.F.D. No. City or Town County State <i></i>						
22a. I certify that (I) (this hospital) attended the deceased from <i>MAY 10, 1968</i> , to <i>MAY 20, 1968</i> , that (I) (we) lost saw the deceased alive on <i>MAY 20, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>George W. Tittle</i>					DEGREE <i></i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5/20/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>George W. Tittle</i>					22e. ADDRESS <i>Bel Air md</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>5-24-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Asbury Church</i>		23d. LOCATION (City or Town) (County) (State) <i>Bel Air Harford md</i>					
24. FUNERAL DIRECTOR <i>George W. Tittle</i>					ADDRESS <i>Bel Air md</i>		25a. REC'D BY REGISTRAR DATE <i>MAY 29 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>		

11000

STATE OF NEW YORK

11000

3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				CERTIFICATE OF DEATH				
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
EMMA Reynolds Bradford					May 10 1968			3:00 PM
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female	White	JUNE 2, 1900			67 YRS.		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Md.		U.S.A.				HARFORD Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
HAURE de GRACE		HARFORD Memorial Hosp.			HOUSE WIFE		HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md		HARFORD		HAURE de GRACE				812 Conesto St.
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME			
THOMAS				SAMPSON	MARY MARGARET SANGLETON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT				
				STHEL NEIOLEIN 812 CONESTO, ST. HARFORD MD 21078				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unstable angina (heart disease)</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 day</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
4/20/1								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>4/27</u> , 19 <u>68</u> to <u>5/10</u> , 19 <u>68</u> that (I) (we) last saw the deceased alive on <u>May 10</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
Charles W. Smith								5/11/68
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		MAY 13, 1968		ROCK RUN CEM.		HARFORD Co Md.		
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
R. Madison Mitchell				HAURE de GRACE, Md. 21078		MAY 15 1968		Charles Judge

1

IN SENATE,
January 15, 1883.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
FOR THE YEAR
1882.
BY
J. W. HARRIS,
COMMISSIONER.
DALLAS: PUBLISHED BY
J. W. HARRIS.
1883.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68.

MIDDLE				MIDDLE				MIDDLE			
07084				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				7390			
1. DECEASED-NAME (Type or print) First Middle Last Veronica Frances Brinegar				2a. DATE OF DEATH Month 5 Day 7 Year 68				2b. HOUR 4 PM			
3. SEX F		4. RACE W		5. DATE OF BIRTH June 18, 1923		6. AGE (In years last birthday) 44 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Pa		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Hartford Md.					
10. CITY OR TOWN OF DEATH 66 Havre de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 12 Harford Memorial Assembly Line Worker		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY Shoe factory					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2814 Pulaski Highway			
14. FATHER'S NAME First Middle Last Peter Luczewski		15. MOTHER'S MAIDEN NAME First Middle Last Ann Lisowski		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no							
16b. SOCIAL SECURITY NO. 195-14-7755		17. INFORMANT Address Edgewood, Md. William V. Brinegar, 2814 Pulaski Highway.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 180X DUE TO, OR AS A CONSEQUENCE OF (b) Ca. of Cervix Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months 6-7 months											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 171X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE-OF-DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 4-16-68, to 5-7-68, that (I) (we) last saw the deceased alive on 5-7-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Edward C. Loo, M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/7/68	
22d. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.		22e. ADDRESS Havre de Grace, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 10, 1968		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Bel Air Harford Md					
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE 10 1968		25b. REGISTRAR'S SIGNATURE					

35084

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15-41
30M REV. 1/68

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07085

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07092

1. DECEASED-NAME (Type or print) First Middle Last <i>Pearline Boddy Cain</i>			2a. DATE OF DEATH Month Day Year <i>MAY 15 1968</i>			2b. HOUR <i>3:00</i> AM <input checked="" type="checkbox"/> PM <input type="checkbox"/>			
3. SEX <i>Female</i>		4. RACE <i>Colored</i>		5. DATE OF BIRTH <i>2/2/1898</i>		6. AGE (in years lost birthday) <i>70</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>HARFORD</i> Md.			
10. CITY OR TOWN OF DEATH <i>HAURE de Grace</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>HARFORD Memorial Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>Port Deposit</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>R D 1 - Box 111</i>	
14. FATHER'S NAME First Middle Last <i>George B. Boddy</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Caroline La Rue</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>219-42-0465</i>		17. INFORMANT <i>Hospital Records</i>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>4120</i> IMMEDIATE CAUSE (a) <i>Uremia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>HEVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>443X</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>April 30, 1968</i> , to <i>May 15, 1968</i> , that (I) (we) lost saw the deceased alive on <i>May 15, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Lajos Mezei</i>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>May 18, 1968</i>			
22d. PHYSICIAN'S NAME (Type) <i>Lajos Mezei, M.D.</i>		22e. ADDRESS <i>Haure de Grace, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>May 18, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hosanna Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Darlington, Harford Md.</i>			
24. FUNERAL DIRECTOR <i>Lee A. Patterson & Son, Perryville, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>May 24 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
07086
07092
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>		c. LENGTH OF STAY IN 1b <u>Joppa</u>	
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>		d. STREET ADDRESS <u>2111 Singer Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Beatrice</u> Middle <u>R.</u> Last <u>Chase</u>		4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>1968</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25, 1924</u>
9. AGE (In years last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>3</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Myers</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Benjamin Chase</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>4100</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> (c) <u>Congestive heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>years</u> <u>months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4201</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 4, 1968</u> , to <u>present</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/1</u> 19 <u>68</u> , and that death occurred at <u>12:01</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Phyllis K. Pullen</u>		22b. DATE SIGNED <u>5/15/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>Phyllis K. Pullen</u>		22d. ADDRESS <u>Jerusalem Rd., Kingville, Md. 21087</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burned</u>		23b. DATE THEREOF <u>May 20 1968</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baldwin Natl Cem</u>		23d. LOCATION (City, town or county) (State) <u>5501 Federal Cir.</u>	
24. FUNERAL DIRECTOR <u>John P. Elchorn 1129 D. Caroline St</u>		25a. REC'D BY REGISTRAR <u>MAY 17 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>John P. Elchorn</u>		25c. REGISTRAR'S SIGNATURE <u>John P. Elchorn</u>	

1988

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 413 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Allen B. Cohee		2a. DATE OF DEATH Month Day Year May 26, 1968		2b. HOUR 9:25 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Sept 21, 1900	
6. AGE (In years lost birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MD		7b. CITIZEN OF WHAT COUNTRY? US.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. COUNTY OF DEATH HARFORD		Md.			
10. CITY OR TOWN OF DEATH HAVERDE GRACE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN HAVERDE GRACE	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 202 N. Washington			
14. FATHER'S NAME First Middle Last Frank H. Cohee		15. MOTHER'S MAIDEN NAME First Middle Last Josephine Coulbourn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. 214-10-0591A		17. INFORMANT Address Elbert Cohee - Frank Mt.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 1519 DUE TO, OR AS A CONSEQUENCE OF (b) Ca. of the Stomach Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 151X DUE TO, OR AS A CONSEQUENCE OF (c) ? APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Malnutrition + Anemia, Secondary to Cancer					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from May 22, 1968, to May 26, 1968, that (I) (we) last saw the deceased alive on May 26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edward C. Loo		DEGREE M.D.		22c. DATE SIGNED 5/26/68	
22d. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.		22e. ADDRESS Haverde Grace, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 29, 1968		23c. NAME OF CEMETERY OR CREMATORY Zion Cemetery	
23d. LOCATION (City or Town) (County) (State) Federalburg, Md. rural					
24. FUNERAL DIRECTOR Harvey Williams		ADDRESS Federalburg, Md.		25a. REC'D BY REGISTRAR DATE JUN 4 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge					

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Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4)
30M REV. 1/68

07088

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07094

1. DECEASED NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		Month		Day		Year		2b. HOUR	
John Alexander CORNWELL								May		22		1968		10:35		PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.		9. IF UNDER 1 YEAR		10. IF UNDER 24 HRS.		11. IF UNDER 1 YEAR	
male		white		August 12, 1895		72		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH											
Virginia		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		HARFORD											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY											
HAVERDE GRACE		HARFORD Memorial Hosp.		Farmer		Farm											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET AND NUMBER											
Md.		HARFORD		Aberdeen		YES <input type="checkbox"/> NO <input type="checkbox"/>		RFD-3 Box 219									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last			
Jake		Cornwell		(D)				Belle Whitaker		(D)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address											
Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)				Leo J. Cornwell		R.D. 3, Aberdeen, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		SUBARACHNOID HEMORRHAGE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		6 hrs							
4120		DUE TO, OR AS A CONSEQUENCE OF		(b)		HYPERTENSION AND CORONARY DISEASE		unknown									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF		(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		443x															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
				YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19															
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County		State					
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>																	
22a. I certify that (I) (this hospital) attended the deceased from 5-22-68, 19, to 5-22-68, 19, that (I) (we) last saw the deceased alive on May 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS											
B.J. Plunkett Jr.		5-23-68		B.J. Plunkett Jr.		M.D.											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)							
Burial		25 May 68		Bel Air Memorial Gardens		Bel Air		Harford Co.		Md.							
24. FUNERAL DIRECTOR		Tarring Funeral Home		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Walter Macomber Jr.		Aberdeen, Md. 21003		MAY 27 1968		Charles Judge											

1004

CENTRAL BANK OF DENMARK

03083

AMOUNT OF THE CHECK IN WORDS

1000 00/100
ONE THOUSAND DOLLARS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07089

07095

1. DECEASED-NAME (Type or print) Edna May Cullum			2a. DATE OF DEATH Month 5 Day 12 Year 1968			2b. HOUR 9:45 P.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH May 10/1909		6. AGE (In years last birthday) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.				
10. CITY OR TOWN OF DEATH Harre-de-Grace			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WIFE			12b. KIND OF BUSINESS OR INDUSTRY SAME	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md			13b. COUNTY Harford			13c. CITY OR TOWN Harre-de-Grace			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 626 N. Stokes St			14. FATHER'S NAME First William Middle Nautilus Last Lutz			15. MOTHER'S MAIDEN NAME First Carrie Middle Adams Last Adams				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. no			17. INFORMANT Mr Leo Martha Cullum			Address 626 N. Stokes St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1950 IMMEDIATE CAUSE (a) Carcinomatosis, intra-abdominal DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 1992									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Marked Anemia due to Carcinomatosis										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 5/12/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Edward C. Loo, MD			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 5/12/68	
22d. PHYSICIAN'S NAME (Type) Edward C. Loo, MD			22e. ADDRESS Harre-de-Grace, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 5/14/1968			23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery			23d. LOCATION (City or Town) (County) (State) Harford Md	
24. FUNERAL DIRECTOR Clenington Ben, Harre-de-Grace, Md.			ADDRESS			25a. REC'D BY REGISTRAR DATE 6... 20 1968			25b. REGISTRAR'S SIGNATURE James Jones	

MEDICAL CERTIFICATION

48351

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

<div style="display: flex; justify-content: space-between;"> 07090 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 07096 </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>											
1. DECEASED-NAME (Type or print) Edna F Deaton						2a. DATE OF DEATH Month May Day 30 Year 1968		2b. HOUR 5 A. M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH Apr. 28, 1893		6. AGE (In years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN _____	
7a. BIRTHPLACE (State or foreign country) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Co., Md.					
10. CITY OR TOWN OF DEATH Bel Air			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 500 Bel Air Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Homemaker		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 500 Bel Air Road		
14. FATHER'S NAME First Middle Last Walter --- McClure				15. MOTHER'S MAIDEN NAME First Middle Last Margaret --- Cohenour							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 213-50-2232		17. INFORMANT (Husband) 838-3080 Mr. Glen C. Deaton			Address P.O. Box #254 Bel Air, Md. 21014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ch Arteriosclerosis Cardio-vascular Disease DUE TO, OR AS A CONSEQUENCE OF: (c) _____ 6 yrs.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 None											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____							
22a. I certify that (I) (this hospital) attended the deceased from Jan 17, 1963 , to May 30, 1968 , that (I) (we) last saw the deceased alive on May 1, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Willard P. Hudson, M.D.						DEGREE _____ ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED May 30, 1968			
22d. PHYSICIAN'S NAME (Type) Willard P. Hudson						22e. ADDRESS Forest Hill, Maryland 21050					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 1, 1968		23c. NAME OF CEMETERY OR CREMATORY Fallston Meth. Ch. Cem.		23d. LOCATION (City or Town) (County) (State) Fallston, Harford Co., Md.					
24. FUNERAL DIRECTOR Joseph William Foster W. Broadway & Williams St. Bel Air, Maryland 21014						25a. REC'D BY REGISTRAR DATE JUN 3 1968		25b. REGISTRAR'S SIGNATURE Charles J. J...			

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Journal of Interpersonal Violence

Stoits, Anna Maria, 744-10

ALLEN SONG

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) Eula V. Devine						2a. DATE OF DEATH Month 5 Day 13 Year 68			2b. HOUR 11:25 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 11-17-23			6. AGE (In years last birthday) 44 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.					
10. CITY OR TOWN OF DEATH Havre de Grace, MD.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Citizens Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Havre de Grace		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 111 Weber St.,		
14. FATHER'S NAME First Middle Last Caleb A. Beard				15. MOTHER'S MAIDEN NAME First Middle Last Florence J. Kilburn							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. none		17. INFORMANT Address George W. Devine, Havre de Grace, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral & Osseous metastases 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Right Breast DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10/67 6/66	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 170X											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 2/19/68 , 19__, to 5/13/68 , that (I) (we) last saw the deceased alive on 5/13/68 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE A.W. Grigoleit MD				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/13/68					
22d. PHYSICIAN'S NAME (Type) A.W. GRIGOLEIT				22e. ADDRESS HAVRE de GRACE							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 16, 1968		23c. NAME OF CEMETERY OR CREMATORY Mt. Nebo		23d. LOCATION (City or Town) (County) (State) Delta York Penna					
24. FUNERAL DIRECTOR John H. Harkins				ADDRESS Delta, Penna.		25a. REC'D BY REGISTRAR DATE MAY 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

07070

07070

11-17-62	11-17-62	11-17-62	11-17-62
11-17-62	11-17-62	11-17-62	11-17-62
11-17-62	11-17-62	11-17-62	11-17-62

James de Grace, JR. 04/10/62
 Maryland 11-17-62
 James de Grace, JR. 11-17-62

10/67
 6/66

General & Counsel in Foster
 Governor of Calif. State

2/10/62
 2/10/62

2/10/62

2/10/62

AW ERICOLEIT
 2/10/62

James de Grace

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A 514
30M REV 7/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) ^{First} <u>I d A</u> ^{Middle} <u>Elizabeth</u> ^{Last} <u>Dowd</u>			2a. DATE OF DEATH ^{Month} <u>May</u> ^{Day} <u>13</u> ^{Year} <u>68</u>			2b. HOUR <u>1 A</u> ^M					
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>March 9, 1898</u>		6. AGE (In years last birthday) <u>70</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <u>W. VA.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Harford</u> Md.					
10. CITY OR TOWN OF DEATH <u>Have de Grace</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Harford Memorial Hospital</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>Md</u>			13b. COUNTY <u>Harford</u>		13c. CITY OR TOWN <u>Belt Air</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <u>Route 1 - Forge Hill Rd.</u>		
14. FATHER'S NAME ^{First} <u>John</u> ^{Middle} <u>Dillon</u> ^{Last}			15. MOTHER'S MAIDEN NAME ^{First} <u>Ellen</u> ^{Middle} <u>Thomas</u> ^{Last}								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>NO</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>272-14-5921</u>		17. INFORMANT (Husband) <u>838-4039</u> Address <u>2241 1st, Box #163, Belt Air, Maryland 21014</u>		Mr. John J. Dowd					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>4120</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive and Arteriosclerotic</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiovascular Disease</u> <u>several years</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>443X</u>											
19a. DATE OF OPERATION <u>5/13/68</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <u>19</u> Month <u>5</u> Day <u>13</u> Year <u>1968</u> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE-BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <u>5/10</u> City or Town <u>1968</u> County <u>5/13</u> State <u>1968</u>							
22a. I certify that (I) (this hospital) attended the deceased from <u>5/13</u> <u>1968</u> to <u>5/13</u> <u>1968</u> , that (I) (we) last saw the deceased alive on <u>5/13</u> <u>1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Edmund C. Loo, M.D.</u>		DEGREE <u>M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>5/13/68</u>					
22d. PHYSICIAN'S NAME (Type) <u>Edmund C. Loo, M.D.</u>		22e. ADDRESS <u>Have de Grace, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>May 15, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Belt Air Memorial Gardens</u>		23d. LOCATION (City or town) <u>Belt Air Harford Co., Maryland 21014</u> (County) (State)					
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>		ADDRESS <u>W. B. Roadway & Co. Williams St. Belt Air, Maryland 21014</u>		25a. REC'D BY REGISTRAR <u>16 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

02010

STATE OF TEXAS

02010

IN SENATE,
January 10, 1901.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE.

TRANSMITTED TO THE SENATE
January 10, 1901.

COMMISSIONER OF THE LAND OFFICE
STATE OF TEXAS

REPORT OF THE
COMMISSIONER OF THE
LAND OFFICE.

FOR THE YEAR
ENDING DECEMBER 31, 1900.

PRESENTED TO THE SENATE
JANUARY 10, 1901.

BY THE COMMISSIONER OF THE
LAND OFFICE.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-1-68
30M REV. 1-68

<div style="display: flex; justify-content: space-between;"> 07092 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 07099 </div> <div style="text-align: center;"> CERTIFICATE OF DEATH </div>																	
1. DECEASED-NAME (Type or print)				First Middle Last				2a. DATE OF DEATH				2b. HOUR					
Henry J. Eiford Sr.								Month 5 Day 9 Year 68				10:45 PM					
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 YRS.					
M		W		1-12-04				64 YRS.		MONTHS		DAYS					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH				Md.					
Balto. Md.		USA		WIDOWED		DIVORCED		Harford									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY					
Hawthorne				609 Legion Drive				Supt. General Cable Co.									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER							
Md.				Baltimore		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3457 Mayfield Ave.							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME													
First Middle Last				First Middle Last													
George P. Eiford				Annie Bleach													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.				17. INFORMANT				Address					
no				214-01-5155				Helen Wareheim Eiford, wife, above									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Coronary thrombosis																	
DUE TO, OR AS A CONSEQUENCE OF																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
4201																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
								YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				HOUR A.M. Month Day Year P.M. 19													
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION		City or Town		County State					
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>								5-6		5-7		1968					
22a. I certify that (I) (this hospital) attended the deceased from 5-6, 1968, to 5-7, 1968, that (I) (we) last saw the deceased alive on 5-7, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE								DEGREE		ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.		22c. DATE SIGNED	
John D. Yarn										<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS									
John D. Yarn								Hawthorne									
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)							
Burial				5/13/68		Holy Redeemer Cemetery				Baltimore, Md.							
24. FUNERAL DIRECTOR								ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Schimunek Funeral Home, Inc.								3331 Brehms Lane		DATE		MAY 13 1968					
												Charles Judge					

• DN • 93 14

with mind for

DOI: 10.1002/for

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07094

07100

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First KATHRYN	Middle A	Last ELLIOT T	2a. DATE OF DEATH Month May Day 13 Year 1968		2b. HOUR 1010 PM
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH July 16, 1932		6. AGE (In years lost birthday) 35 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Colorado		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.	
10. CITY OR TOWN OF DEATH Aberdeen Prov Gr		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kirk Army Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Store Manager		12b. KIND OF BUSINESS OR INDUSTRY PX	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Harford		13c. CITY OR TOWN APG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First PETER Middle DENSON Last DENSON		15. MOTHER'S MAIDEN NAME First ANN Middle ALLEN Last ALLEN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			
16b. SOCIAL SECURITY NO. 522-347847		17. INFORMANT Address Junius R. Elliott 2756 E Augusta, APG, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma, Lung, not proven</u> 162.1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 163X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>March 28</u> , 19 <u>68</u> , to <u>May 14</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>May 14</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Phillip P. Roberts</u> M.D. DEGREE				22c. DATE SIGNED 13 May 1968		22d. ADDRESS Kirk Army Hospital, APG, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-17-68		23c. NAME OF CEMETERY OR CREMATORY National Cemetery		23d. LOCATION (City or town) (County) (State) Washington D.C.	
24. FUNERAL DIRECTOR <u>Charles E. Bullard</u> <u>Harford, Md</u>				25a. REC'D BY REGISTRAR DATE MAY 20 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

20770



FOR STATE HEALTH DEPT.

1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 2-PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07095 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												07101			
Item 2a, Film GL 01 6/3/ MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or Print) <u>Charlotte Reray Ensor</u>						2a. DATE KNOWN <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> OF ESTI-DEATH MATED <input type="checkbox"/> Not Known?						2b. HOUR <input type="checkbox"/> M			
3. SEX <u>F</u>		4. RACE <u>W</u>		5. DATE OF BIRTH <u>2/25/1968</u>		6. AGE (In years last birthday) <u>3</u> YRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD Month <u>May</u> Day <u>25</u> Year <u>1968</u>		2d. HOUR <input type="checkbox"/> M	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>			7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <u>Harford</u> Md.						
10. CITY OR TOWN OF DEATH <u>White Hall</u>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Troyer Road</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>None</u>				12b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>						13b. COUNTY <u>Harford</u>		13c. CITY OR TOWN <u>White Hall</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <u>Troyer Road</u>			
14. FATHER'S NAME First <u>Charles</u> Middle <u>William</u> Last <u>Ensor</u>						15. MOTHER'S MAIDEN NAME First <u>Gora</u> Middle <u>Ann</u> Last <u>Hensley</u>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16b. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT ADDRESS <u>Mrs. Cora Ann Ensor Troyer Road White Hall, Md. 21161</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <u>795x</u> IMMEDIATE CAUSE (a) <u>SPH</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>---</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>---</u>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>7955</u>															
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u>19</u> P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Gerald C. Palmer</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						22b. DATE SIGNED <u>5-25-68</u>			
EXAMINER'S NAME (Type) <u>Gerald C. Palmer</u>						ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE <u>5/27/1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Stablersville</u>				23d. LOCATION (City or Town) (County) (State) <u>Stablersville, Balto. Md.</u>					
24. FUNERAL DIRECTOR <u>Charles E. Kurtz</u>						ADDRESS <u>Jarrettsville, Md. 21084</u>		25a. REC'D BY REGISTRAR <u>MAY 28 1968</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



Dear Sir:
I have the honor to acknowledge the receipt of your letter of the 2nd inst. in relation to the matter of the above-captioned case.
The Bureau is at present unable to give you any definite answer, but will endeavor to do so as soon as possible.
Very respectfully,
J. H. ...

Very truly yours,
J. H. ...
Special Agent in Charge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos. 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) Michael			First Middle Last			2a. DATE OF DEATH MAY Month 19 Day 1968 Year			2b. HOUR 10¹⁰ AM		
3. SEX Male			4. RACE White			5. DATE OF BIRTH April 24, 1895			6. AGE (In years last birthday) 73 YRS.		
7a. BIRTHPLACE (State or foreign country) ITALY			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH HARFORD Md.		
10. CITY OR TOWN OF DEATH HAVERDE GRACE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD MEMORIAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD			13b. COUNTY HARFORD			13c. CITY OR TOWN HAVERDE GRACE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER 971 Chesapeake Drive			14. FATHER'S NAME First Middle Last UNKNOWN			15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)		
16b. SOCIAL SECURITY NO. UNK			17. INFORMANT Mrs Frank Cianelli			Address 971 Chesapeake Dr			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Emphysema pulm. DUE TO, OR AS A CONSEQUENCE OF (b) 492X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5271											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State			22a. I certify that (I) (this hospital) attended the deceased from APRIL 26, 1968 , to MAY 19, 1968 , that (I) (we) last saw the deceased alive on MAY 19, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		
22b. SIGNATURE LAJOS Mczei			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type) LAJOS Mczei			22e. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
23b. DATE 5/22/68			23c. NAME OF CEMETERY OR CREMATORY St Josephs Cemetery			23d. LOCATION (City or Town) (County) (State) Columbus Ohio			25a. REC'D BY REGISTRAR Charles Judge		
24. FUNERAL DIRECTOR Henry Haverde Grace, Md			ADDRESS			25b. REGISTRAR'S SIGNATURE			DATE MAY 24 1968		

MEDICAL CERTIFICATION

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print) <i>Lawrence E. Friar</i>			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <i>5-17 1968</i>			2b. HOUR <i>10:30</i> M		
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>4/19/1950</i>		6. AGE (In years last birthday) <i>18</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month <i>5</i> Day <i>17</i> Year <i>68</i>		2d. HOUR <i>10:30</i> M		
7a. BIRTHPLACE (State or foreign county) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Harford</i>			Md.		
10. CITY OR TOWN OF DEATH <i>Harford</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford General Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Student</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>---</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Edgewood Arsenal</i>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME <i>Clyde L. Friar</i>			First Middle Last			15. MOTHER'S MAIDEN NAME <i>Constance B. Lovejoy</i>			First Middle Last Md.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>215-56-6858</i>			17. INFORMANT ADDRESS <i>Col. Clyde L. Friar, Edgewood Arsenal, Edgewood, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture Skull</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Crushing Injury L Chest</i> (b) <i>---</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>---</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>8254</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR <i>10</i> P.M. <i>5-17 1968</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Anti-Air</i>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>US Forest Service Rd</i>			21f. LOCATION Street or R.F.D. No. City or Town County State <i>Aberdeen Ha Md.</i>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Gerald P Palmer</i>			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>5-18-68</i>		
EXAMINER'S NAME (Type) <i>Gerald P Palmer</i>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>May 21, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Edgewood Arsenal Cem.</i>			23d. LOCATION (City or Town) (County) (State) <i>Edgewood Arsenal-Harford-Md.</i>			
24. FUNERAL DIRECTOR <i>Lee A. Patterson & Son, Perryville, Md.</i>						25a. REC'D BY REGISTRAR DATE <i>MAY 24 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

07098 Item#665 FilmG403 8/1/68 Item#5, Film#G401 5/31/68 km		DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		7104	
1. DECEASED-NAME (Type or print) First Middle Last ROBERT GEIDE		2a. DATE OF DEATH Month Day Year May 23 Day Year 68		2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Sept. 4, 23 21/9000/1896 last birthday 1892 YRS.	
7a. BIRTHPLACE (State or foreign country) Binghamton, N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (In years last birthday) 1892 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH Aberdeen Prov Gnd. Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2005 Apt 4 APG., Md.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Mason	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE N.Y.		13b. COUNTY Broome Co.		13c. CITY OR TOWN Shenango	
14. FATHER'S NAME First Middle Last Unknown		15. MOTHER'S MAIDEN NAME First Middle Last Unknown		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no	
16b. SOCIAL SECURITY NO. 064-14-9419		17. INFORMANT Address Cpt Carl R. Ross, 2005 Aberdeen Prov Gdn Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 185x Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (b) Prostatic carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 177x none				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from MAY 17, 1968, to MAY 23, 1968, that (I) (we) last saw the deceased alive on MAY 17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W. A. Councill, Jr. M.D.				22c. DATE SIGNED 5/24/68	
22d. PHYSICIAN'S NAME (Type) W. A. Councill, Jr., M.D.M				22e. ADDRESS 611 S. Union Ave. Havre de Grace Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 25 May 68		23c. NAME OF CEMETERY OR CREMATORY Kattelville Cemetery	
24. FUNERAL DIRECTOR W. A. Councill, Jr.		25a. REC'D BY REGISTRAR MAY 24 1968		25b. REGISTRAR'S SIGNATURE John J. Judge	

72740. (120-4)

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VR A1
30M REV. 11-68

07092				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				07105			
Item #6, Film #G400 5/23/68km				CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) HARRY		First		Middle		Last		2a. DATE OF DEATH Month MAY Day 11 Year 68		2b. HOUR 10 55 A M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 11/14/1901		6. AGE (In years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD Md.					
10. CITY OR TOWN OF DEATH HAURE DE GRACE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD Memorial Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Police Dept		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY HARFORD		13c. CITY OR TOWN HAURE DE GRACE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 359 LEWIS ST			
14. FATHER'S NAME First Harry B. Middle Hadray Last Hadray		15. MOTHER'S MAIDEN NAME First Nathune Middle Kubler Last Kubler									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 208		17. INFORMANT Address 359 Lewis Wilhelmina Hadray Harford							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia bilateral 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral & Pulmonary Infarction 1 week DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4200											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 5/4/ , 19 68 , to 5/11/ , 19 68 , that (I) (we) last saw the deceased alive on MAY 11 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the cause(s) stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Wm H. Wuelman		22c. DATE SIGNED 5/4/68		22d. PHYSICIAN'S NAME (Type)							
22e. ADDRESS											
23a. BURIAL/CREMATION, REMOVAL (Specify)		23b. DATE 5/14/68		23c. NAME OF CEMETERY OR CREMATORY Angel Hill		23d. LOCATION (City or Town) (County) (State) Harford Grace Md.					
24. FUNERAL DIRECTOR Funerary Co. Harford Grace Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 20 1968		25b. REGISTRAR'S SIGNATURE James Judge					

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

07100 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07106

1. DECEASED-NAME (Type or Print) FREDERICK			First Middle Last HARDWICK			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year 5/11 1968			2b. HOUR OF DEATH 11:15 A.M.					
3. SEX male		4. RACE white		5. DATE OF BIRTH 12/6/1921		6. AGE (In years last birthday) 46 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year May 11, 1968		2d. HOUR OF DEATH 11:15 A.M.		
7a. BIRTHPLACE (State or foreign country) Charmell Conn.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Harford				Md.	
10. CITY OR TOWN OF DEATH Havre de Grace				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) U.S. Marine				12b. KIND OF BUSINESS OR INDUSTRY Government		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 1520 Osborn Road				
14. FATHER'S NAME First Middle Last Frederick Hardwick						15. MOTHER'S MAIDEN NAME First Middle Last Wilhelmina Luckman								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) W.W. 2				16b. SOCIAL SECURITY NO. yes		17. INFORMANT Attitude Hardwick				ADDRESS 1520 Osborn Rd. Aberdeen Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> 22b. DATE SIGNED 5/12/68 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)														
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE 5/15/68		23c. NAME OF CEMETERY OR CREMATORY Angel Hill				23d. LOCATION (City or Town) (County) (State) Havre de Grace, Md.				
24. FUNERAL DIRECTOR Anthony J. R...				ADDRESS Havre de Grace, Md.				25a. REC'D BY REGISTRAR DATE MAY 20 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 1 1
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <i>Hilda Christopher Harward</i>			3a. DATE OF DEATH Month <i>May</i> Day <i>16</i> Year <i>1968</i>			2b. HOUR <i>9⁰⁰ A M</i>				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>26 January 1908</i>		6. AGE (In years last birthday) <i>60</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Harford</i> Md.				
10. CITY OR TOWN OF DEATH <i>Harre de Grace</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial Hosp</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Aberdeen</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>436 W. Bel Air Ave</i> <i>P.O. Box 417</i>	
14. FATHER'S NAME First <i>J.</i> Middle <i>William</i> Last <i>Hester (D)</i>				15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>White</i> Last <i>(D)</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>N/A</i>		17. INFORMANT Address <i>J. Burleigh Harward, Aberdeen, Maryland</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>monocytic leukemia</i> <i>206X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 mos</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>2042</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>5-15-68</i> , 19____, to <i>5-16-68</i> , 19____, that (I) (we) last saw the deceased alive on <i>5-16-68</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>B.J. Plunkett Jr.</i> M.D. DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>5-16-68</i>		
22d. PHYSICIAN'S NAME (Type) <i>B.J. Plunkett Jr. M.D.</i>					22e. ADDRESS <i>617 W. Bel Air Ave. Aberdeen, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>18 May 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Spesutia Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Perryman, (Harford) Md.</i>				
24. FUNERAL DIRECTOR <i>Walter Wocanhu Sr.</i> Tarring Funeral Home <i>Aberdeen, Md. 21001</i>					25a. REC'D BY REGISTRAR DATE <i>MAY 20 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last Mac T. HAWKS					2a. DATE OF DEATH Month Day Year MAY 22 1968			2b. HOUR 11:05 AM		
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH February 24, 1900			6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD Md.				
10. CITY OR TOWN OF DEATH HAVERDE GRACE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD MEMORIAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md			13b. COUNTY HARFORD		13c. CITY OR TOWN Churchville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Rt 1	
14. FATHER'S NAME First Middle Last James H. Thomas (D)					15. MOTHER'S MAIDEN NAME First Middle Last Lillie Bare (D)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 217-26-7400-B		17. INFORMANT Address James Hawks, RD. 2, Aberdeen, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Atrial fibrillation DUE TO, OR AS A CONSEQUENCE OF (c) A-S.C.V.D. + Old Rheumatic heart disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chromosomal Pneumonia (2) Tumor in right lower lung APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days > 10 yrs. > 10 years										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from MAY 4, 1968 to MAY 22, 1968 , that (I) (we) last saw the deceased alive on MAY 22, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Edward C. Loo, M.D.					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/22/68			
22d. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.		22e. ADDRESS Haverde Grace, Ind.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 25 May 1968		23c. NAME OF CEMETERY OR CREMATORY Southern Cemetery			23d. LOCATION (City or Town) (County) (State) Dublin, Harford Md.			
24. FUNERAL DIRECTOR Helene Macomber Jr.					ADDRESS Tarring Funeral Home Aberdeen, Md. 21001		25a. REC'D BY REGISTRAR DATE MAY 27 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) Leo George Kracke						2a. DATE OF DEATH Month May Day 12 Year 68			2b. HOUR 11:05 PM		
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 15 1883			6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN 0
7a. BIRTHPLACE (State or foreign country) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.					
10. CITY OR TOWN OF DEATH Harre de Grace			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Interior Decorator			12b. KIND OF BUSINESS OR INDUSTRY Retired		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 345 RFD		
14. FATHER'S NAME First John Middle Henry Last Kracke				15. MOTHER'S MAIDEN NAME First Dora Middle Cluever							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 355-07-4891		17. INFORMANT Address Mr. Robert D. Kracke Bel Air, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Posterior Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Coronary Thrombosis (b) A.S. O.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) ? APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days 6 days ?											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201 Pneumonitis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month May Day 7 Year 1968 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. May 7th, 1968, to May 12, 1968		City or Town Chicago		County Ill.		State Ill.	
22a. I certify that (I) (this hospital) attended the deceased from May 7th, 1968 , to May 12, 1968 , that (I) (we) last saw the deceased alive on May 12, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Edward C. Loo, M.D.						DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/12/68	
22d. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.						22e. ADDRESS Harre de Grace, Ind.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE May 13, 1968		23c. NAME OF CEMETERY OR CREMATORY Ferns Funeral Home		23d. LOCATION (City or Town) Chicago		(County) Ill.		(State) Ill.	
24. FUNERAL DIRECTOR Howard K. McComas & Son						ADDRESS Abingdon, Md.		25a. RECEIVED BY REGISTRAR MAY 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-9. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR
Walter David Labrenz						May 25 1968			6:20 PM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	March 28, 1921	47 YRS			May 25 1968			6:20 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pittsburgh, Pa.		U.S.A.				Harford County,			Md.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Havre de Grace		DCA Harford Memorial Hospital				Tool Specialist		U.S. Govt.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
Maryland			Harford		Bel Air	1508 Conowingo Road			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Edward David Labrenz			Ruth Henrietta Triplett						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. (If no, give year or dates of service)		17. INFORMANT (Mother) 838-3536		ADDRESS P.O. Box #328		
Yes			WW #2		Mrs. Ruth H. Labrenz		Bel Air, Md. 21014		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Gerald C. Palmer</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <u>May 27, 1968</u>			
EXAMINER'S NAME (Type) <u>Gerald C. Palmer, M.D.</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County)		
Burial			May 28, 1968		Mt. Zion Meth. Ch. Cem.		Bel Air, Harford Co., Md. 21014		
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>					25a. REC'D BY REGISTRAR DATE <u>MAY 28 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <i>CLARA Pennington MAGNESS</i>						2a. DATE OF DEATH Month Day Year <i>May 23 1968</i>			2b. HOUR MIN <i>8:30 A</i>		
3. SEX <i>Female</i>		4. RACE <i>W</i>		5. DATE OF BIRTH			6. AGE (In years last birthday) <i>87</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>HARFORD</i> Md.					
10. CITY OR TOWN OF DEATH <i>Harrods de Grace, Md.</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Mem. Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>HARFORD</i>		13c. CITY OR TOWN <i>Bel Air</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Box 469</i>		13f. Bel Air, Md.	
14. FATHER'S NAME First Middle Last <i>Lambert Pennington</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Maurice Wetherall</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO. <i>2125-52-1508</i>		17. INFORMANT Address <i>Marie Johnson, Bel Air Md</i>							
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF <i>Recurrent + Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>A.S.C.V.D.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4201</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i> <i>> 10 years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes mellitus and terminal Pneumonia</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>5/18</i> , 19 <i>68</i> , to <i>May 23</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>May 23</i> , 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Edward C. Loo, M.D.</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5/23/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Edward C. Loo, M.D.</i>		22e. ADDRESS <i>Harrods de Grace, Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE <i>May 28, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mountain Christian</i>		23d. LOCATION (City or Town) (County) (State) <i>Joppa Harford Md</i>					
24. FUNERAL DIRECTOR <i>W. Starcher</i>		ADDRESS <i>21018 Benson Rd</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
				DATE <i>MAY 28 1968</i>							

MEDICAL CERTIFICATION

RECEIVED

1917

San Antonio

San Antonio, Texas
March 1, 1917
Dear Sir:
I have the honor to acknowledge the receipt of your letter of the 28th inst. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.
Very respectfully,
J. M. [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
071106									
07112									
1. DECEASED-NAME (Type or print) Jessie Van Trump Markline			2a. DATE OF DEATH Month May Day 15 Year 1968				2b. HOUR 6:50 M		
3. SEX F		4. RACE W		5. DATE OF BIRTH Sept. 14, 1891		6. AGE (In years lost birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD Md.			
10. CITY OR TOWN OF DEATH Harve de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial School		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) teacher		12b. KIND OF BUSINESS OR INDUSTRY Education			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Cecil		13c. CITY OR TOWN Park Deposit		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Colora Road RFI	
14. FATHER'S NAME First Middle Last Simeon J. Van Trump				15. MOTHER'S MAIDEN NAME First Middle Last Jennie Trout					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, as an unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 212-38-2315		17. INFORMANT Address Donald D. Markline Parkton, Md. 21120					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure 1560 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Gall Bladder DUE TO, OR AS A CONSEQUENCE OF (c) ? APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1551 ASCVD									
19a. DATE OF OPERATION 5/16/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Jaundice		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3/9 , 19 68 , to 3/15 , 19 68 , that (I) (we) last saw the deceased alive on 3/15/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles E. Kurtz MD				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/15/68			
22d. PHYSICIAN'S NAME (Type) A. W. GRIGOLEIT				22e. ADDRESS Harve de Grace					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/18/1968		23c. NAME OF CEMETERY OR CREMATORY Vernon		23d. LOCATION (City or Town) (County) (State) White Hall, Balto. Md.			
24. FUNERAL DIRECTOR Charles E. Kurtz Jarrettsville, Md.				25a. REC'D BY REGISTRAR MAY 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

21084

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

15ME (5)
REV. 1/68

1. DECEASED-NAME (Type or Print)		First Charles - Middle Emory Last Mitchell		2a. DATE KNOWN <input checked="" type="checkbox"/> Month 5 - Day 6 Year 1968		2b. HOUR OF DEATH MATED <input type="checkbox"/> 5-6 1968	
3. SEX M	4. RACE W	5. DATE OF BIRTH 4 July 1890	6. AGE (in years last birthday) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford	
10. CITY OR TOWN OF DEATH Harford		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Self-employed	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Churchville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Samuel Middle Bryson Last Mitchell (D)		15. MOTHER'S MAIDEN NAME First Alice Middle Wakeland Last (D)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 216-09-7958	
17. INFORMANT ADDRESS Mrs. Isabel H. Mitchell, Churchville, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing injury chest = multiple rib fractures (R)</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>rib fractures (R)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		19. DATE OF OPERATION 5-6-68	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year 5-6-68 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) Tractor Overturned on him	
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. Churchville		City or Town Harford	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. DATE SIGNED 5-5-68		22c. NAME OF CEMETERY OR CREMATORY Churchville Presbyterian		22d. LOCATION (City or Town) (County) (State) Churchville, (Harford) Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9 May 1968		23c. NAME OF CEMETERY OR CREMATORY Churchville Presbyterian		23d. LOCATION (City or Town) (County) (State) Churchville, (Harford) Md.	
24. FUNERAL DIRECTOR Tarring Funeral Home Aberdeen, Md. 21001		25a. REC'D BY REGISTRAR MAY 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE MAY 10 1968	

MEDICAL CERTIFICATION

8113

10112

10112

MAY 10 1968

RECEIVED

U.S. DEPARTMENT OF AGRICULTURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last VERNA Owens		2a. DATE OF DEATH Month Day Year MAY 22 1968		2b. HOUR 4:30 A.M.
3. SEX Female	4. RACE white	5. DATE OF BIRTH JAN 26 1915		6. AGE (In years lost birthday) 53 YRS.
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. COUNTY OF DEATH HARFORD		Md.		
10. CITY OR TOWN OF DEATH HAURE de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD Memorial Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE
12b. KIND OF BUSINESS OR INDUSTRY SAME				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY HARFORD		13c. CITY OR TOWN HAURE de Grace
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 708 Fountain St.		
14. FATHER'S NAME First Middle Last LESLIE EARL HILTON		15. MOTHER'S MAIDEN NAME First Middle Last ANNIE LAURIE COX		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) NO NO		16b. SOCIAL SECURITY NO. YES		17. INFORMANT Mrs. James B Owens, Revolution St Hlths.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis - Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331X				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from 1968, to 5/22, 1968, that (I) (we) last saw the deceased alive on May 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE [Signature]		22c. DATE SIGNED 5/22/68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 05/25/1968		23c. NAME OF CEMETERY OR CREMATORY Angel Hill Cemetery
23d. LOCATION (City or Town) (County) (State) Harrods Grace Harford Md		23e. REC'D BY REGISTRAR DATE MAY 28 1968		
24. FUNERAL DIRECTOR Carrington & Son		25b. REGISTRAR'S SIGNATURE Charles Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07109

07115

1. DECEASED-NAME (Type or print) First Middle Last Wesley Curtis Paxton			2a. DATE OF DEATH Month Day Year 5-9-68		2b. HOUR 4:48 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH Nov. 18, 1903		6. AGE (In years lost birthday) 64 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Md	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH HARFORD Md.		
10. CITY OR TOWN OF DEATH Harford	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY R.P.G.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md	13b. COUNTY Cecil	13c. CITY OR TOWN Port Deposit	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER RD # 1	
14. FATHER'S NAME First Middle Last Lawrence Paxton		15. MOTHER'S MAIDEN NAME First Middle Last Margaret Ann Sinclair			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Marion C. Paxton Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4419 Rupture aortic aneurysm. DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.U. II. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 451X					
19a. DATE OF OPERATION 5-9-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Rupture aneurysm		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 5-7, 1968, to 5-9, 1968, that (I) (we) last saw the deceased alive on 5-9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Wm. K. Brendle MD				22c. DATE SIGNED 5-9-68	
22d. PHYSICIAN'S NAME (Type) Wm. K. Brendle MD				22e. ADDRESS Harford, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/12/1968	23c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		23d. LOCATION (City or Town) (County) (State) Port Deposit, Md.
24. FUNERAL DIRECTOR Lee A. Patterson & Son			25a. REC'D BY REGISTRAR DATE MAY 17 1968		
			25b. REGISTRAR'S SIGNATURE Charles Judge		

03102

STATE OF OHIO

1911

RECEIVED

Wm. A. Swartz

For the State of Ohio, the undersigned, Wm. A. Swartz, Clerk of the Supreme Court, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the files of the Court.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

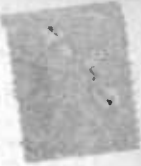
07110

07116

1. DECEASED-NAME (Type or print) Susan		First A. Middle A. Last Payne		2a. DATE OF DEATH Month May Day 18 Year 68		2b. HOUR 1505 M	
3. SEX Female		4. RACE Caucasion		5. DATE OF BIRTH 2 Mar 47		6. AGE (In years last birthday) 21 YRS.	
7a. BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford	
10. CITY OR TOWN OF DEATH Aberdeen P.G.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kirk Army Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Harve DeGrace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Darrel Middle L. Last Blackmore		15. MOTHER'S MAIDEN NAME First Elenor Middle Burkovitch Last Md.		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. None	
17. INFORMANT Wilford D. Payne, 718 N. Stokes, Harve DeGrace		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ulcerative Colitis 5631 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5722 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pregnancy	
19a. DATE OF OPERATION 1965		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ulcerative Colitis		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from 7 May , 19 68 , to 18 May , 19 68 , that (I) (we) last saw the deceased alive on 18 May , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE William G. Stein	
22c. DATE SIGNED 18 May 68		22d. PHYSICIAN'S NAME (Type) William G. Stein		22e. ADDRESS Kirk Army Hospital, APG, Md.		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 20 May 1968		23c. NAME OF CEMETERY OR CREMATORY Rosewood Memorial Park		23d. LOCATION (City or Town) (County) (State) Virginia Beach, Virginia	
24. FUNERAL DIRECTOR Tarring Funeral Home, Aberdeen, Md. 21001		25a. REC'D BY REGISTRAR DATE MAY 21 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S SIGNATURE	

RECEIVED

0:00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

071112

CERTIFICATE OF DEATH

071117

1. DECEASED-NAME (Type or print) First Middle Last JOE (NMN) RAYSON			2a. DATE OF DEATH Month Day Year MAY 27 1968		2b. HOUR 8:25 M
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 3/3/1883		6. AGE (In years last birthday) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) England	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH HARFORD Md.		
10. CITY OR TOWN OF DEATH HAURE de GRACE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HARFORD Memorial Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerical		12b. KIND OF BUSINESS OR INDUSTRY Self mfg
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY HARFORD	13c. CITY OR TOWN HAURE de GRACE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 313 FOUNTAIN ST.	
14. FATHER'S NAME First Middle Last William Rayson		15. MOTHER'S MAIDEN NAME First Middle Last ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war and dates of service) no		16b. SOCIAL SECURITY NO. 1mb		17. INFORMANT Doris Rayson Address 313 Fountain St. Harford Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Thoracic Aorta 441-1 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic C.V.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs 10 yrs 10 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201 Gout					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from June 3, 1968 , to May 27, 1968 , that (I) (we) last saw the deceased alive on May 27, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael A. ...				22c. DATE SIGNED 5/28/68	
22d. PHYSICIAN'S NAME (Type) E. H. Richardson, M.D.				22e. ADDRESS Post Office ...	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 5/30/68		23c. NAME OF CEMETERY OR CREMATORY Lanhamwood	
23d. LOCATION (City or Town) (County) (State) Shadensburg Pa.		23e. REC'D BY REGISTRAR JUN 3 1968		23f. REGISTRAR'S SIGNATURE Charles ...	
24. FUNERAL DIRECTOR Dunington ...					

11-10

CHIEF OF TRAIN

ALICE

[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]

[Faint, mostly illegible handwritten text along the right margin, possibly a list or notes.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 2, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last PEARL NONE RODES						2a. DATE OF DEATH Month Day Year MAY 17 1968			2b. HOUR M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH JAN 20 1894			6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) IN. VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U S		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD			M.d.			
10. CITY OR TOWN OF DEATH FALLSTON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) —			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE WIFE			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.			13b. COUNTY HARFORD		13c. CITY OR TOWN FALLSTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER CARRS MILL RD.			
14. FATHER'S NAME First Middle Last HENRY F STANLEY			15. MOTHER'S MAIDEN NAME First Middle Last MARTHA HAMMONDS									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO			16b. SOCIAL SECURITY NO. 213-36-8324		17. INFORMANT JESSIE R. CURRY			Address FALLSTON, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4339 Chronic Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years 5 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 332x												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from March , 19 68 , to May , 19 68 , that (I) (we) lost saw the deceased alive on May 9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Charles Richardson						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/13/68				
22d. PHYSICIAN'S NAME (Type) Charles Richardson						22e. ADDRESS P.O. Box 4841, Bel Air, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE May 14 1968		23c. NAME OF CEMETERY OR CREMATORY BEL AIR MEMORIAL			23d. LOCATION (City or Town) (County) (State) BEL AIR HARFORD MD					
24. FUNERAL DIRECTOR ARCHER FUNERAL HOME - BENSON, MD.						25a. REC'D. BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAY 20 1968		

0111

31173

NAME: GEORGE JOHN

DATE: 10/10/50

TO: MR. J. H. HARRIS

FROM: MR. J. H. HARRIS

SUBJECT: [illegible]

RE: [illegible]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>William Henry Ropka</i>			2a. DATE OF DEATH Month <i>5</i> Day <i>7</i> Year <i>68</i>			2b. HOUR <i>5:35</i> A.M.	
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>July 4, 1885</i>		6. AGE (In years last birthday) <i>82</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>MD.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>HARFORD</i> Md.	
10. CITY OR TOWN OF DEATH <i>Harre de Grace</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Citizen's Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Carpenter - Farmer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>US Govt - Ret.</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) STATE <i>MD.</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Joppatowne</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>Rt 2 Box 158</i>		14. FATHER'S NAME First <i>Henry</i> Middle <i>William</i> Last <i>Ropka</i>		15. MOTHER'S MAIDEN NAME First <i>Ida</i> Middle <i>--</i> Last <i>Swimmer</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>no</i>		16b. SOCIAL SECURITY NO. <i>220-20-7451</i>		17. INFORMANT Address <i>Charles W. Ropka, Rt 2, Box 158, Joppa, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decompensation</i> <i>4129</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4221</i> (b) <i>A. S. C. V. D.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized arteriosclerosis</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>1-2 years</i> <i>?</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Pneumonitis</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>4/7</i> , 19 <i>68</i> , to <i>5/7</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>5/3</i> , 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Edward C. Loomis</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>5/7/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Edward C. Loomis</i>		22e. ADDRESS <i>Harre de Grace, Ind.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>May 9, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cokesbury Memorial</i>		23d. LOCATION (City or Town) (County) (State) <i>Abingdon Harford Md</i>	
24. FUNERAL DIRECTOR <i>Howard K. McComas & Son, Abingdon, Md.</i>				25a. REC'D BY REGISTRAR <i>MAY 9 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

0111

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Annie Evelyn Rutledge		2a. DATE OF DEATH Month Day Year May 15 1968		2b. HOUR 10:30 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Aug. 11, 1898	
6. AGE (In years lost birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Harford		10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hosp	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Street	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R 2 Box 74			
14. FATHER'S NAME First Middle Last CALEB E. MERRICK		15. MOTHER'S MAIDEN NAME First Middle Last ANNIE M. RILEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 119-14-2302		17. INFORMANT Address ROBERT RUTLEDGE, STREET, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 420.1 DUE TO, OR AS A CONSEQUENCE OF (b) and Cardiac Decompensation DUE TO, OR AS A CONSEQUENCE OF (c) A.S. C.V.D. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks. ?					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Extensive interstitial pulmonary fibrosis.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4/23, 1968, to 5/15, 1968, that (I) (we) last saw the deceased alive on 5/15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Edward C. Loo, M.D.		22c. DATE SIGNED 5/15/68		22d. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.	
22e. ADDRESS Havre de Grace, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE May 18, 1968		23c. NAME OF CEMETERY OR CREMATORY HIGHLAND	
23d. LOCATION (City or Town) (County) (State) STREET, Harford, Md.					
24. FUNERAL DIRECTOR JOHN H. HARKINS, DELTA, Pa.		25a. RECEIVED BY REGISTRAR MAY 20 1968		25b. REGISTRAR'S SIGNATURE James Judge	

4155

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

81-15, 3

CERTIFICATE OF DEATH

07715

07121

1. DECEASED-NAME (Type or print)		MARK		3. SEX Male		4. RACE Cau		5. DATE OF BIRTH 30 May 1968		2a. DATE OF DEATH Month May Day 30 Year 1968		2b. HOUR 0145 M	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford		6. AGE (In years last birthday) YRS. 32		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 01 MIN. 45	
10. CITY OR TOWN OF DEATH Aberdeen Prov Gr		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) US Kirk Army Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Harford		13c. STREET AND NUMBER 307 Belfast Court	
14. FATHER'S NAME First Reuben J Sarver		Middle J		Last Sarver		15. MOTHER'S MAIDEN NAME First Patrina D Smith		Middle D		Last Smith		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) N/A	
16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Reuben J Sarver		Address 307 Belfast Ct Joppatown		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac & Respiratory Arrest 7762 DUE TO, OR AS A CONSEQUENCE OF (b) Prematurity DUE TO, OR AS A CONSEQUENCE OF (c) 		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 7735		19a. DATE OF OPERATION 7735	
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month May Day 30 Year 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 		21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 		21f. LOCATION Street or R.F.D. No. 		City or Town 		County 		State 		22a. I certify that (X) (this hospital) attended the deceased from 29 May , 1968, to 30 May , 1968, that (X) (we) last saw the deceased alive on 29 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE RICHARD H HELLER, CPT MC	
22c. DATE SIGNED 30 May 1968		22d. PHYSICIAN'S NAME (Type) Richard H. Heller MD		22e. ADDRESS US KIRK ARMY HOSPITAL, APG, Md. 21005		23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 6/2/1968		23c. NAME OF CEMETERY OR CREMATORY Alexandria National Cem.		23d. LOCATION (City or Town) (County) (State) Pineville Louisiana	
24. FUNERAL DIRECTOR Walter A. ...		25a. REC'D BY REGISTRAR JUN 3 1968		25b. REGISTRAR'S SIGNATURE Charles ...		26. REMARKS 		27. REMARKS 		28. REMARKS 		29. REMARKS 	

1921

STATE OF NEW YORK

11113

201 Robert Court

Applicant

Received of the State of New York
the sum of \$100.00
for the purpose of the
State of New York
the sum of \$100.00
for the purpose of the
State of New York

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMO-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>07116</div> <div> <div>07122</div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> </div>																	
1. DECEASED-NAME (Type or Print)			First			Middle			Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
STANLEY			RALPH			SHEPPARD						Month Day Year			M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR		
male		white		7/5/1915		52 YRS.		MONTHS DAYS		HOURS MIN.		Month Day Year			1:10 P. M.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. COUNTY OF DEATH								
Spartan NC.			U.S.A.			WIDOWED			Harford						Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY								
Havre de Grace			Harford Memorial Hospital														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER					
Maryland			Harford			Havre de Grace			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			618 Green Street					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME														
Hillary Sheppard			Hattie Vannoy														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
No			unb			Josephine Sheppard			618 Green St.			Harford Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Rheumatic Heart Disease																	
398x DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
(b) DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
416x																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?											
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
CAUSE OF DEATH			19 P.M.														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town			County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MEDICAL EXAMINER			22b. DATE SIGNED								
Werner U. Spitz, M.D.						<input checked="" type="checkbox"/>			5/7/68								
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town)			(County) (State)					
			5/10/68			Mt Zion			Near Churchville Md.								
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Pammytho Rm			Harford Place Md.			MAY 9 1968			John Judge								

0150

1997

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07117

CERTIFICATE OF DEATH

07123

1. DECEASED-NAME (Type or print) Baby GIRL Shumate			2a. DATE OF DEATH Month 5 Day 24 Year 68			2b. HOUR 8:58 P	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 5-23-68		6. AGE (In years lost birthday) YRS. - MONTHS - DAYS 24	
7a. BIRTHPLACE (State or foreign country) Hartford, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Hartford. Md.	
10. CITY OR TOWN OF DEATH Harrode-Grace		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hartford Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md.		13b. COUNTY Hartford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 302 North Main Street							
14. FATHER'S NAME First Middle Last Gary John Shumate			15. MOTHER'S MAIDEN NAME First Middle Last Grace Elizabeth Lane				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT Father 838-8390 Mr. Gary J. Shumate Address 302 North Main St. Bel Air, Maryland 21014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia (drowning) & vomitus 7720 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) massive ASPIRATION (vomiting). DUE TO, OR AS A CONSEQUENCE OF (c) vomiting (new born)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7628 INTRACRANIAL HEMORRHAGE?							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 5-23, 1968 , to 5-24, 1968 , that (I) (we) last saw the deceased alive on 5:49 PM 5/24/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Alonso Gomez, M.D.				DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/25/68.	
22d. PHYSICIAN'S NAME (Type) Alonso Gomez, M.D.				22e. ADDRESS 419 S. Union Ave - Harrode de Grace			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE MAY 25, 1968		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Bel Air Hartford Co, Maryland 21014	
24. FUNERAL DIRECTOR JOSEPH William Foster W. Broadway Williams St. Bel Air, Maryland 21014				25a. REC'D BY REGISTRAR DATE MAY 28 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The" and "and" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the registrar, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 7-60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Mary P. Silver</i>		2a. DATE OF DEATH Month <i>5</i> Day <i>7</i> Year <i>68</i>		2b. HOUR <i>6:23 PM</i>
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>Oct. 27, 1893</i>	6. AGE (In years last birthday) <i>74</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>md</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Hartford</i> Md.	
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hartford Memorial</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>HOUSE WIFE</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>md</i>	13b. COUNTY <i>Hartford</i>	13c. CITY OR TOWN <i>Havre de Grace</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <i>1010 Harrison Blvd</i>
14. FATHER'S NAME First <i>William</i> Middle <i>J.</i> Last <i>Price</i>	15. MOTHER'S MAIDEN NAME First <i>Sarah</i> Middle <i>Courtney</i> Last <i>Courtney</i>	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		
16b. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT Name <i>Albert C. Silver</i> Address <i>Havre de Grace Md. 21078</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>410.9</i> IMMEDIATE CAUSE (a) <i>Acute Coronary / Myocardial</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201</i>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>May 5</i> , 19 <i>60</i> , to <i>May 7</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>5/7</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Dudley Phillips</i>	DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>5/8/68</i>		
22d. PHYSICIAN'S NAME (Type) <i>Dudley Phillips MD</i>	22e. ADDRESS <i>Darlington md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>MAY 10, 1968</i>	23c. NAME OF CEMETERY OR CREMATORY <i>HARMONY Pres. Ch. Yard</i>	23d. LOCATION (City or Town) <i>Hartford</i>	(County) <i>C.</i> (State) <i>Md.</i>
24. FUNERAL DIRECTOR <i>R. Madison Mitchell</i>	ADDRESS <i>Havre de Grace Md.</i>	25a. REC'D BY REGISTRAR DATE <i>MAY 13 1968</i>	25b. REGISTRAR'S SIGNATURE <i>John Judge</i>	

31150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last Lola May Simmons						2a. DATE OF DEATH Month Day Year MAY 14 1968			2b. HOUR 6:40 M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MAY 23 March 1899			6. AGE (In years last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.						
10. CITY OR TOWN OF DEATH Harford			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Harford			13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 426 S. Phila. Blvd.		
14. FATHER'S NAME First Middle Last Herman H. Rheem (D)				15. MOTHER'S MAIDEN NAME First Middle Last Rose Collison (D)								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No				16b. SOCIAL SECURITY NO. 216-36-5815		17. INFORMANT Address Goldie S. McGrady, Aberdeen, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 491 X IMMEDIATE CAUSE (a) Congestive heart failure, right DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema and chronic bronchitis DUE TO, OR AS A CONSEQUENCE OF (c) > 10 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 5020												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from MAY 11, 1968 , to MAY 14, 1968 , that (I) (we) lost saw the deceased alive on MAY 14, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE B.J. Plunkett Jr.						M.D. DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-14-68		
22d. PHYSICIAN'S NAME (Type) B.J. Plunkett Jr.						22e. ADDRESS Aberdeen, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 17 May 1968		23c. NAME OF CEMETERY OR CREMATORY Jarrettsville Cemetery		23d. LOCATION (City or Town) (County) (State) Jarrettsville (Harford Md.)						
24. FUNERAL DIRECTOR ADDRESS Tarring Funeral Home, Aberdeen, Md. 21001						25a. REC'D BY REGISTRAR MAY 17 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge				

MEDICAL CERTIFICATION

21150

21150

21150

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07126

1. DECEASED-NAME (Type or print) <i>Elijah</i> First <i>Smith</i> Middle Last			2a. DATE OF DEATH Month <i>MAY</i> Day <i>29</i> Year <i>1968</i>			2b. HOUR <i>2:10</i> ^A _M	
3. SEX <i>Male</i>		4. RACE <i>Colored</i>		5. DATE OF BIRTH <i>March 2, 1881</i>		6. AGE (In years last birthday) <i>87</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>HARFORD</i> Md.	
10. CITY OR TOWN OF DEATH <i>HAVER de Grace</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>HARFORD Memorial Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Garmer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>HARFORD</i>		13c. CITY OR TOWN <i>HAVER de Grace</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>257 Lewis St.</i>		14. FATHER'S NAME First <i>Issac</i> Middle <i>Smith</i> Last		15. MOTHER'S MAIDEN NAME First <i>No Record</i> Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>212-18-7870</i>		17. INFORMANT <i>Mr. Eugene Smith</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decompensation</i> <i>4129</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>A.S.C.V.D.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>—</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>?</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4221</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR <i>—</i> AM <i>—</i> Month <i>—</i> Day <i>19</i> Year <i>—</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>August 15, 1968</i> , to <i>May 29, 1968</i> , that (I) (we) last saw the deceased alive on <i>May 29, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Edward C. Loo</i>				22c. DATE SIGNED <i>5/29/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>Edward C. Loo, M.D.</i>				22e. ADDRESS <i>Haver de Grace, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>June 2, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Berkley Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Darlington, Harford, Md.</i>	
24. FUNERAL DIRECTOR <i>Otha J. Bullock, Haver de Grace, Md.</i>				25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03180

RECEIVED

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03180

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year			2b. HOUR M				
Katherine Irene Smith								May 29 1968			5:40 AM				
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
Female		White		Sept. 5, 1913				54 YRS.							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. COUNTY OF DEATH				Md.			
New Jersey		USA						HARFORD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of waking life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY						
HARFORD		HARFORD Memorial Hosp.				Clerk			P.O. Dept.						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER							
Md.		HARFORD		Abingdon				4004 Philadelphia Rd.							
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last	
Charles		--		Birkmire				Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT				Address							
no		218-09-9064		James L. Smith, 4002 Phila Rd, Abingdon, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 5719 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Advanced Chronic Liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>3mo</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5810															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION		Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>68</u> , to <u>May</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>May 29</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE		22c. DATE SIGNED				22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
J. Ralph Horkey, M.D.		5/29/68				J. Ralph Horkey, M.D.		Churchville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)					
Burial		June 1, 1968		Bel Air Memorial Gardens		Bel Air		Harford		Md					
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Howard K. McComas & Son						Abingdon, Md.		JUN 3 1968		J. Ralph Horkey					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

<div style="text-align: center;"> <p>07122</p> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p>Item 1, Film G401 8-20-68 CMC</p> <p>CERTIFICATE OF DEATH</p> <p>07128</p> </div>											
1. DECEASED-NAME (Type or print) <i>DAWAY</i> First <i>Lori</i> Middle <i>Ann</i> Last <i>STANCILL</i>				2a. DATE OF DEATH Month <i>May</i> Day <i>12</i> Year <i>68</i>				2b. HOUR <i>1:40</i> M			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>MAY 11, 1968</i>				6. AGE (In years last birthday) YRS. <i>1</i>		IF UNDER 1 YEAR MONTHS <i>1</i> DAYS <i>24</i> HRS. <i>12</i> MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Harford</i> Md.					
1d. CITY OR TOWN OF DEATH <i>HAURE DE GRACE</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial Hosp</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>NONE</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>				13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Joppa</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>1101 Oak Ave.</i>	
14. FATHER'S NAME First <i>Raymond</i> Middle <i>STANCILL</i> Last <i>STANCILL</i>				15. MOTHER'S MAIDEN NAME First <i>Deborah</i> Middle <i>Gail</i> Last <i>McKenen</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>NO</i> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>Raymond Stancill</i> Address <i>Joppa, Maryland</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>485X</i> IMMEDIATE CAUSE (a) <i>Brachy pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>763.0</i> (b) <i>aspiration syndrome</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 Day</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Acute coarctation & patent ductus arteriosus</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>5-11</i> , 19 <i>68</i> , to <i>5-12</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>5-12</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Alonso Gomez</i>						22c. DATE SIGNED <i>5/13/68</i>					
22d. PHYSICIAN'S NAME (Type) <i>Alonso Gomez M.D.</i>						22e. ADDRESS <i>419 S. Union Ave Harford Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>May 13, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Harford Memorial Gardens</i>				23d. LOCATION (City or Town) (County) (State) <i>Aldino Harford Md.</i>			
24. FUNERAL DIRECTOR <i>Howard K. McComas & Son</i>						ADDRESS <i>Abingdon, Maryland</i>		25a. REC'D BY REGISTRAR DATE <i>MAY 16 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

81-12345

1153

1153



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
07123 CERTIFICATE OF DEATH 07129

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> c. LENGTH OF STAY IN b1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARRS MILL RD.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>CARRS MILL RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First (MONTY) Middle Last <u>MONTREVILLE M. SWETNAM</u>				4. DATE OF DEATH Month Day Year <u>May 26 1968</u>							
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 25, 1910</u>		9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AVIATION</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MANOH SWETNAM</u>				14. MOTHER'S MAIDEN NAME <u>HENRIETTA APPEL</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>218 03 5051</u>		17. INFORMANT <u>Mrs. Margaret E. Swetnam</u> Address <u>Carrs Mill Rd.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebrovascular accident</u> <u>4120</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>hypertensive cardiovascular disease</u> DUE TO (c) <u>3 yrs</u>										INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>443 Kidney stone 24 hrs before</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May 25, 1968</u> to <u>May 26, 1968</u> , that (I) (we) last saw the deceased alive on <u>May 25 1968</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Phyllis K. Pullen</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>May 26, 1968</u>			
22c. PHYSICIAN'S NAME (Type) <u>Phyllis K. Pullen</u>						22d. ADDRESS <u>Box 381, Jerusalem Rd, Kingsville Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>5-29-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CAMP GRACEL Cem.</u>			23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>			
24. FUNERAL DIRECTOR <u>Harry H. Pullen - 2334 Jefferson St</u> ADDRESS <u>Jefferson St</u>						25a. REC'D BY REGISTRAR <u>DATE 27 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

11123

CERTIFICATE OF DEATH

01123



Montevideo M. Z. STANLEY
M. W. 21
August 1902
Age 21
Cause of death
Died at
Place of death
Buried at
Date of burial
Signature of physician
Signature of registrar
Date of registration

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH			2b. HOUR
William		Berkley		Teb		October 1, 1892		MAY 29 1968			4:15 A.M.
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.	
Male	white		October 1, 1892			75 YRS.		MONTHS DAYS HOURS MIN.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH					
Martinsburg, W.Va.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		HARFORD Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
HAURE de Grace		HARFORD Memorial Hosp.									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md		HARFORD		Toppa		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 251 Rd-2.			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
William		E.		Teb				Amand V.		Frankenbury	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No				212-10-8121A		Mrs. Clara Tebo		Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (d) Metastatic Ca. of prostate											
185X DUE TO, OR AS A CONSEQUENCE OF											
(b) Ca. of prostate											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Pneumonitis & Arteriosclerotic Cardiovascular disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from 5/5, 1968, to 5/29, 1968, that (I) (we) last saw the deceased alive on 5-29-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE								22c. DATE SIGNED			
H. CHUNG M.D. DEGREE								May 29, 1968			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS							
H. CHUNG				Harford Memorial Hosp. H.D.C.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		5-31-1968		Bel Air Mem. Gardens		Bel Air		Md.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Wm. Cook-Brooks Towson				1050 York Rd. Towson, Md.		DATE MAY 31 1968		Charles Judge			

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Milton Raymond Walker			2a. DATE OF DEATH Month May , Day 6 , Year 1968			2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH March 4, 1892		6. AGE (In years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.			
10. CITY OR TOWN OF DEATH Forest Hill		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 343 Bynum Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming			
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Forest Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 343 Bynum Road	
14. FATHER'S NAME First Middle Last Abram Baldwin Walker			15. MOTHER'S MAIDEN NAME First Middle Last Mary Ellen Brookhart						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service) ---		16b. SOCIAL SECURITY NO. 217-36-4663		17. INFORMANT Mrs. Frank Stec		Address RD #1 Box 314 Abingdon, Md. 21009			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 431.9 IMMEDIATE CAUSE (a) Coronary atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (b) ? DUE TO, OR AS A CONSEQUENCE OF (c) 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Coronary atherosclerosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles E. Kurtz		DEGREE MD		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/6/68			
22d. PHYSICIAN'S NAME (Type) Charles E. Kurtz		22e. ADDRESS Deputy Medical Examiner Hq. Co							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5/8/1968		23c. NAME OF CEMETERY OR CREMATORY Jarrettsville		23d. LOCATION (City or Town) (County) (State) Jarrettsville, Maryland			
24. FUNERAL DIRECTOR Charles E. Kurtz		ADDRESS Jarrettsville, Md.		25a. REC'D BY REGISTRAR DATE MAY 8 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07126

07132

1. DECEASED-NAME (Type or print) JOHN Jr. CHARLES WALSH			2a. DATE OF DEATH Month MAY Day 2 Year 1968			2b. HOUR 428P M	
3. SEX MALE		4. RACE CAU		5. DATE OF BIRTH APRIL 29, 1968		6. AGE (In years last birthday) YRS. 4	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford	
10. CITY OR TOWN OF DEATH Aberdeen Prov Gr.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kirk Army Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Havre de Grace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Charles J Middle Walsh Last Rodis		15. MOTHER'S MAIDEN NAME First Mary Middle M Last Rodis		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) N/A			
16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Address Charles Walsh, 864 Erie St, Havre De Grace, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 7762 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Respiratory Distress DUE TO, OR AS A CONSEQUENCE OF (c) Birth Birth							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7735							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (he) (this hospital) attended the deceased from April 29, 1968 , to May 2, 1968 , that (he) (we) last saw the deceased alive on May 2, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE George R. Stanley DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED May 2, 1968	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE MAY 6, 1968		23c. NAME OF CEMETERY OR CREMATORY A.P.B. Military Cem. on Post.		23d. LOCATION (City or Town) (County) (State) A.P.B. ABERDEEN Harford Md.	
24. FUNERAL DIRECTOR W. Madison Mitchell		ADDRESS Havre de Grace Md.		25a. REC'D BY REGISTRAR DATE MAY 7 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MAINTENANCE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07127		07133									
1. DECEASED-NAME (Type or print) MARtha		First Middle Last WestERfield		2a. DATE OF DEATH Month May Day 20 Year 1968		2b. HOUR- 6:30 M					
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH June 12, 1901		6. (In years lost birth day) 66 YRS.		IF UNDER 1 YEAR MONTHS 1 DAYS 1		IF UNDER 24 HRS. HOURS 1 MIN. 30	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford		Md.			
10. CITY OR TOWN OF DEATH Harrods Creek, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Hosp.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Md.		13b. COUNTY Harford		13c. CITY OR TOWN Harrods Creek		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1107 Post Road			
14. FATHER'S NAME First Middle Last Raymond L. Westerfield		15. MOTHER'S MAIDEN NAME First Middle Last Lulu M. St. Clair									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. 212-40-6576		17. INFORMANT Hospital Records, Harf. Mem. Hosp.,		Address Harrods Creek, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral metastases 162-1 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma left lung DUE TO, OR AS A CONSEQUENCE OF (c) 6 months								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 163X ASEVD											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 4/16 , 19 68 , to 5-20 , 19 68 , that (I) (we) last saw the deceased alive on 5-20 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								22b. SIGNATURE As Grigoleit MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) A. W. GRIGOLEIT		22e. ADDRESS Harrods Creek									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 23, 1968		23c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		23d. LOCATION (City or Town) (County) (State) Port Deposit Cecil Md.					
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Md.		25a. REC'D BY REGISTRAR MAY 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge							

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or Print) Robert + Martin Williams						2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year May 10 1968		2b. HOUR M					
3. SEX M		4. RACE W		5. DATE OF BIRTH SEPT. 6, 1903		6. AGE (in years last birthday) 64 HRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>			
7a. BIRTHPLACE (State or foreign country) CARDIFF, MD			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Hartford			Md.		
10. CITY OR TOWN OF DEATH CARDIFF				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD				13b. COUNTY Hartford				13c. CITY OR TOWN Cardiff		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Dooly Rd	
14. FATHER'S NAME First CALEB Middle E. Last WILLIAMS				15. MOTHER'S MAIDEN NAME First MARY Middle WILLIAMS Last									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. 220-03-0301		17. INFORMANT MARGARET. HAMILTON, COVINGTON, KY.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CSW Cortex Brown 955X DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) 976X													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot Self							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. Dooly Rd Cord. 95		City or Town Hartford		County MD		State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Gerold P Palmer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 5-10-68					
EXAMINER'S NAME (Type) Gerold P Palmer				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE MAY 14, 1968		23c. NAME OF CEMETERY OR CREMATORY SLATE ROGE		23d. LOCATION (City or Town) DELTA, YORK, PENNA.		(County)		(State)			
24. FUNERAL DIRECTOR JOHN H. HARKINS, DELTA, PA.						25a. REC'D BY REGISTRAR MAY 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

07129		07135	
1. DECEASED-NAME (Type or print) Robert		First Middle Last Rowland Woodrow	
2a. DATE OF DEATH Month May Day 18 Year 1968		2b. HOUR 9:30 AM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH June 22, 1880	6. AGE (In years lost birthday) 87 YRS.
7a. BIRTHPLACE (State or foreign country) Childes, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
9. COUNTY OF DEATH Harford		Md.	
10. CITY OR TOWN OF DEATH Havre de Grace, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Citizens Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) State Road Dept.	12b. KIND OF BUSINESS OR INDUSTRY U.S.A.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. CITY OR TOWN Cecil ✓	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER R.F.D.
14. FATHER'S NAME First Middle Last John A Woodrow	15. MOTHER'S MAIDEN NAME First Middle Last Matelda Spence		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO. 017-14-3700A	17. INFORMANT Address Bessie Cramer Hanover Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca. of Colon c Metastasis 1538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) = DUE TO, OR AS A CONSEQUENCE OF (c) =			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH about 1 year.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1538 A.S.C.D.			
19a. DATE OF OPERATION 1538	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED A.S.C.D.	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from June 6th, 1967 , to May 18th, 1968 , that (I) (we) last saw the deceased alive on May 18, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Edward C. Loo, M.D.	DEGREE EDUCATION	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 5/20/68
22d. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.	22e. ADDRESS Havre de Grace, Md		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 5-21-68	23c. NAME OF CEMETERY OR CREMATORY Harmony Chapel	23d. LOCATION (City or Town) (County) (State) Port Deposit Cecil Md.
24. FUNERAL DIRECTOR Bernice McPherson	ADDRESS Kising Sun	25a. REC'D BY REGISTRAR MAY 22 1968	25b. REGISTRAR'S SIGNATURE Charles Judge

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